SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Standard Security Life Insurance Company of New York

Product Name: Act 1179 Compliance - Hearing Aids - STM	SERFF Tr Num: IADC-126564611	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 45300
Sub-TOI: H16G.004 Short Term	Co Tr Num: SSL HEARING AID RIDER STM	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Shellie Howard	Disposition Date: 05/17/2010
	Date Submitted: 03/30/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 05/17/2010	Explanation for Other Group Market Type:
	State Status Changed: 05/17/2010
Deemer Date:	Created By: Shellie Howard
Submitted By: Shellie Howard	Corresponding Filing Tracking Number: IADC-126160130/IADC-126329616

Filing Description:

Hearing aid benefit rider to comply with Act 1179 and bulletin 7A-2009. Please see cover letter for additional details.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Shellie Howard, Forms Development & Compliance Specialist
howards@iacusa.com
2101 W. Peoria Ave
Suite 100
Phoenix, AZ 85029-4925
602-861-6070 [Phone]

Filing Company Information

Standard Security Life Insurance Company of New York	CoCode: 69078	State of Domicile: New York
485 Madison Avenue	Group Code: 450	Company Type: Life and Health
New York, NY 10022-4141	Group Name:	State ID Number:
(212) 355-4141 ext. [Phone]	FEIN Number: 13-5679267	

Filing Fees

Fee Required?	Yes
Fee Amount:	$60.00
Retaliatory?	No
Fee Explanation:	$20 per form 3 forms x $20=$60
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Security Life Insurance Company of New York	$60.00	03/30/2010	35261427
Standard Security Life Insurance Company of New York	$40.00	05/17/2010	36595183

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/17/2010	05/17/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application	Shellie Howard	05/17/2010	05/17/2010
Form	Application	Shellie Howard	05/17/2010	05/17/2010
Form	Policyholder Election Form	Shellie Howard	05/17/2010	05/17/2010
Supporting Document	Application	Shellie Howard	05/17/2010	05/17/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Update on AR filing	Note To Reviewer	Shellie Howard	04/22/2010	04/22/2010
Filing Fees	Note To Filer	Rosalind Minor	04/02/2010	04/02/2010

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/17/2010
Implementation Date:
Status: Approved-Closed
Comment:

As requested, the applications are being withdrawn and the election form is being approved.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document *(revised)*	Application	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	3rd Party Authorization	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	[Optional] Hearing Aid Rider	Approved-Closed	Yes
Form *(revised)*	Application	Withdrawn	Yes
Form	Application	Withdrawn	Yes
Form *(revised)*	Application	Withdrawn	Yes
Form	Application	Withdrawn	Yes
Form	Policyholder Election Form	Approved-Closed	Yes

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 05/17/2010

Comments:

Good afternoon, this filing has been revised and we respectfully withdraw our request for approval for the following application forms:

SSL-STM-0310A-APP-AR & SSL-STM-0310-APP0-AR. I have added in lieu of modifying the applications a policyholder election form number SSL AEAR OPT ELC AR 0410, for a total of 2 forms submitted for approval. I am also sending an additional $40.00 to make up the difference in the filing fee.

Thank you for your continued review of this filing.

Sincerely,

Shellie Howard

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
SSL-STM-0310A-APP-AR	Application/Enrollment Form	Application	Revised		IADC-126160130	SSL-STM-0109-APP		
SSL-STM-0310-APP-AR	Application/Enrollment Form	Application	Revised		IADC-126329616	SSL-STM-0909-APP		
SSL AEAR OPT ELC AR 0410	Other	Policyholder Election Form	Initial					SSL AEAR OPT ELC AR 0410 for filing 042310.pdf

Supporting Document Schedule Item Changes:

Satisfied -Name: Application

Comment: Application SSL-STM-0909-APP approved 10/6/09 State Tracking #43669

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Application SSL-STM-0109-APP approved 05/28/09 State Tracking #42460

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Shellie Howard on 04/22/2010 10:31 AM

Last Edited By:

Rosalind Minor

Submitted On:

05/17/2010 03:26 PM

Subject:

Update on AR filing

Comments:

Good morning Rosalind, I am going to be sending updated forms in addition to those already indicated, and updating the application to make the hearing aid benefit rider a policyholder option. So the new form will be a policyholder option form, and at that time I will send in the appropriate fees. This would apply to all the filing I submitted for SSL, MNL, and IAIC, it's just going to take me a couple of days to update the forms. Your understanding and patience is very much appreciated, and if you would like to discuss on the phone please call me or give me your number and I can call you. My number here is 6022-861-6070.

Thank you,
Shellie Howard

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Note To Filer

Created By:
Rosalind Minor on 04/02/2010 02:36 PM
Last Edited By:
Rosalind Minor
Submitted On:
05/17/2010 03:26 PM
Subject:
Filing Fees
Comments:

Our filing fees under Rule 57 has been updated. Please review the General Instructions for ArkansasLH.

The new fee for this submission would be $50.00 per form for a total of $150.00. Please submit an additional $90.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: SSL STM HEARAIDAE AR 0310

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/17/2010	SSL STM HEARAIDAE AR 0310	Certificate Amendment, Insert Page, Endorsement or Rider	[Optional] Hearing Aid Rider	Initial			SSL STM HEARAIDAE AR 0310 (Optional Hearing Aid Rider)032910.pdf
Withdrawn 05/17/2010	SSL-STM-0310A-APP-AR	Application/ Enrollment Form	Application	Revised	Replaced Form #: SSL-STM-0109-APP Previous Filing #: IADC-126160130		
Withdrawn 05/17/2010	SSL-STM-0310-APP-AR	Application/ Enrollment Form	Application	Revised	Replaced Form #: SSL-STM-0909-APP Previous Filing #: IADC-126329616		
Approved-Closed 05/17/2010	SSL AEAR OPT ELC AR 0410	Other	Policyholder Election Form	Initial			SSL AEAR OPT ELC AR 0410 for filing 042310.pdf

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

[485 Madison Avenue, New York, NY 10022]

[OPTIONAL] HEARING AID BENEFIT RIDER FOR ARKANSAS RESIDENTS ONLY

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

If You are covered under the [optional] Hearing Aid Benefit Rider, and if specified as applicable on the Schedule of Benefits, the Certificate is amended as follows:

A. **SECTION II, COVERED EXPENSES, SECTION B, COVERED EXPENSES FOR TREATMENT, SERVICES OR SUPPLIES** the following benefit is added:

[17.] Hearing Aids, not subject to the Deductible or Daily Deductible [or Copay], up to $[1,400] per ear for each [three-year] period. The Hearing Aids must be dispensed by an individual properly licensed by the State of Arkansas.

B. Under the section entitled **LIMITATIONS AND EXCLUSIONS** the following change is hereby made:

Item [#33] pertaining to routine hearing exams is amended by deleting the reference to "the purchase of hearing aids."

C. Under the section entitled **DEFINITIONS** the following definition is added:

Hearing Aid means an instrument or device, including repair and replacement parts, that:

a) Is designed and offered for the purpose of aiding Covered Persons with or compensating for impaired hearing;
b) Is worn in or on the body; and
c) Is generally not useful to a person in the absence of a hearing impairment.

TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2009] or] [Your coverage Effective Date] [whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Rachel Lipari
President

Adam C. Vandervoot
Secretary

SSL STM HEARAIDAE AR 0310

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
[485 Madison Avenue, New York, NY 10022]

POLICYHOLDER ELECTION FORM
ARKANSAS RESIDENTS ONLY

As elected by the Policyholder, and in consideration of any applicable additional premium for each Arkansas resident Certificate holder for each benefit option selected, Covered Charges will include all or any of the following, which will be paid in lieu of any similar benefits described in the Policy. We will not duplicate benefits payable elsewhere under the Policy or any attached Rider.

[1.] Accept _____ Reject _____ Hearing Aids (Act 1179 of 2009/Bulletin 7A-2009)

As the Policyholder, we request that you indicate above whether you accept or reject this optional benefit:

Policyholder Name: _____

Signed for the Policyholder _____

Name _____ Title _____ Date _____

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/17/2010

Comments:

Attachment:

ARCertificate of ComplianceSTM033010.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	05/17/2010

Comments:

Application SSL-STM-0909-APP approved 10/6/09 State Tracking #43669
Application SSL-STM-0109-APP approved 05/28/09 State Tracking #42460

		Item Status:	Status Date:
Satisfied - Item:	3rd Party Authorization	Approved-Closed	05/17/2010

Comments:

Attachment:

SSL Filing Authorization Letter 2010.pdf

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	05/17/2010

Comments:

Attachment:

SSL STM(AR)filing letter 033010.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Standard Security Life Insurance Company of New York (SSL)

Form Number(s):

SSL STM HEARAIDAE AR 0310
SSL STM 0310A-APP-AR
SSL STM 0310-APP-AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.

Signature of Company Officer:

Adam Vandervoort
Name

Secretary
Title

03/30/10
Date

Standard Security
Life Insurance Company
Independence Holding Group

www.sslicny.com

January 6, 2010

RE: Standard Security Life Insurance Company of New York

NAIC Company Number:	69078
NAIC Group Number:	0450
FEIN Number:	13-5679267

AUTHORIZATION STATEMENT

Standard Security Life Insurance Company of New York ("SSLICNY") hereby authorizes IHC Health Solutions (Member of the IHC Group), to represent us in the submission of accident and health insurance Group and Individual Policy Forms, and related forms and rates, and to negotiate with the Department for their approval.

Sincerely,

Adam C. Vandervoort
Secretary

IHC Health Solutions
Independence Holding Group

2101 W Peoria Avenue #100
Phoenix, AZ 85029

March 30, 2010

Honorable Jay Bradford
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: Standard Security Life Insurance Company of New York

NAIC Company Number:	69078
NAIC Group Number:	0450
FEIN Number:	13-5679267

Group Short Term Medical Insurance Policy – SSL-STMP-1104

New Form:

SSL STM HEARAIDAE AR 0310	[Optional] Hearing Aid Benefit Rider

Revised Form:

SSL STM 0310 APP AR	Application
SSL STM 0310A APP AR	Application

Dear Commissioner Bradford:

We are submitting for your review and approval, the above referenced out-of-state Group Policy forms on behalf of Standard Security Life Insurance Company of New York {SSL}. This filing is being made in order to comply with Bulletin 7A-2009 & Act 1179 of 2009 regarding the mandatory offering of hearing aids. The Hearing Aid Benefit Rider is a new form and will not replace any approved forms currently on file with the Department. The application form (SSL STM 0310A APP AR) was revised to reflect the new hearing aid option. This form will replace form #(SSL STM 0109 APP) approved 05/28/09 under State Tracking #42460, SERFF #IADC-126160130 and the application form (SSL STM 0310 APP AR), also revised to include the hearing aid benefit, will replace form #(SSL STM 0909 APP) approved 10/6/09 under State Tracking #43669, SERFF #IADC-126329616. We will list this rider on the Schedule of Benefits as applicable or not applicable, depending on the applicant's selection.

IHC has received authorization to file life, accident, and health forms on SSL's behalf. For your reference, we have enclosed the filing letter of authorization from SSL. Additionally, we have also included a Certification signed by an officer of SSL, in accordance with Rule and Regulation 19.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions. We confirm that the forms meet the minimum required readability standards.

For any questions or if any additional information is needed, please contact me at (602)-861-6070, or by email: howards@iacusa.com. Thank you for your prompt consideration of this filing.

Sincerely,

Shellie Howard

Shellie Howard
Form Development & Compliance Specialist

PH: 602-861-6070

SERFF Tracking Number:	*IADC-126564611*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*45300*
Company Tracking Number:	*SSL HEARING AID RIDER STM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*Act 1179 Compliance - Hearing Aids - STM*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/30/2010	Form	Application	05/17/2010	SSL-STM-0310A-APP-AR (ForFiling{033010}.pdf (Superceded)
03/30/2010	Form	Application	05/17/2010	SSL-STM-0310-APP-AR (ForFiling033010).pdf (Superceded)
03/30/2010	Supporting Document	Application	05/17/2010	SSL-STM-0310A-APP-AR (ForFiling{033010}.pdf (Superceded) SSL-STM-0310-APP-AR (ForFiling033010).pdf (Superceded)

[Plan Name]

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
SHORT TERM MEDICAL INSURANCE APPLICATION

COMPLETE THE FOLLOWING TO INSURE YOURSELF:

Applicant:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex _____

Social Security Number_____

Occupation _____

Telephone _____

Street Address _____

_____

City _____ State _____ Zip_____

Billing Address (if different) _____

_____

City _____ State ____ Zip_____

E-mail address _____

COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND/OR CHILDREN:

Spouse:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex ____

Social Security Number _____

Occupation _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age_____

Social Security Number _____

COMPLETE THE FOLLOWING PLAN CHOICES:

Coverage Effective Date:

[□ Day after US Post Office Date Stamp

□ Later Effective Date: _____

● No more than [60] days in advance]

Coverage Length:

[□ **Single Payment:** *Specify number of days of coverage*

____ days *(minimum [30] days, maximum [365] days)* or

□ **Monthly Payment:**

□ Up to [6] Months

□ Up to [12] Months]

□ **[Secure] STM Plan Coinsurance:**

[□ 80/20 of $5,000 □ 50/50 of $5,000 □ 80/20 of $10,000 □ 50/50 of $10,000 □ 100%]*

*100% not available with $250 or $1,000 Deductible]]

Deductible:

[□$250 □ $500 □ $1,000 □ $2,500 □ $5,000 □ $10,000 □ $25,000]

[□ **Daily Deductible STM Plan Coinsurance:**

Not applicable

Deductible:

□ $250 □ $500 □ $750 □ $1,000]

[□ **Optional Supplemental Accident Benefit**

□ $500 □ $1,000]

[Optional Coverage - Hearing Aids

□ Accept □ Reject]

[Method of Payment

□ Check or Money Order

□ Credit Card

□ Monthly Automatic Bank Withdrawal]

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

Misstatements and omissions may be a material misrepresentation and a basis for rescission of coverage. In the event of rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) all claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be deducted from any premium refund due.

1. Will there be any other group or individual major medical health insurance in force on the policy effective date? ..... □ Yes □ No
2. Is the proposed insured, spouse, or any dependent child now pregnant? ..... □ Yes □ No
3. Have you or any person applying for coverage been declined for health insurance for a condition that is still present? ..... □ Yes □ No
4. Are you or any person applying for coverage currently eligible for Medicaid? ..... □ Yes □ No

[5. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? ..... □ Yes □ No]

[6.] Within the past [5] years have you or any person applying for coverage been aware of, received an abnormal test report for, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for:

■ heart disorder, heart attack, coronary artery disease, coronary bypass or stent ■ peripheral vascular disease or carotid artery disease ■ stroke or other neurological disorder ■ cancer or tumor	■ paraplegia, quadriplegia or multiple sclerosis ■ stem cell transplant ■ emphysema or COPD (chronic obstructive pulmonary disease) ■ diabetes ■ liver disorder	■ kidney disorder other than stones ■ degenerative disc disease or herniated disc ■ rheumatoid or psoriatic arthritis ■ degenerative joint disease of the knees or hips ■ alcohol or drug abuse or dependency ■ hemophilia

..... □ Yes □ No

[7.] Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS ....□ Yes □ No

[[8.]Has any person proposed for coverage not been a legal resident of the United States for the last [12] consecutive months?..... □ Yes □ No]

([**NOTE: IF "YES IS ANSWERED ON ANY QUESTION 1 THROUGH [8], COVERAGE CANNOT BE ISSUED].**)

ACCEPTANCE AND ACKNOWLEDGEMENT:

A. I agree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
B. I hereby request coverage under the policy issued to the group policyholder. I agree to all terms of the group policy if the coverage applied for becomes effective.
C. I understand that the agent or broker who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied (1) was acting as an independent contractor and not as an agent of the Insurance Company; (2) was retained by me as my agent; and (3) has no right to alter the application, bind or approve coverage or alter any of the terms or conditions of the policy.
D. I certify that (1) I have read this application; (2) all of my (our) answers are within my (our) personal knowledge; and (3) all of my (our) answers are complete, true and correct.
E. I agree to immediately notify the insurer of any changes in any of the information contained in this application which may occur prior to the Effective Date of coverage.
F. I understand that health insurance benefits are excluded for pre-existing conditions and this coverage will not pay benefits for a disease or physical condition that I now have or have had within [5] years of my application for coverage.
G. I understand that cancellation of this coverage within the 10 Day Right to Return the Certificate provision as stated in the Certificate of Insurance will result in a refund of premiums only. [Any administrative fees or other fees that may apply will not be refunded].

Signature of Applicant or (Legal Guardian): _____ **Date:** _____

Signature of Spouse: _____ **Date:** _____

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[Plan Name]

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
SHORT TERM MEDICAL INSURANCE APPLICATION

COMPLETE THE FOLLOWING TO INSURE YOURSELF:

Applicant:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex _____

Social Security Number_____

Occupation _____

Telephone _____

Street Address _____

_____

City _____ State _____ Zip_____

Billing Address (if different) _____

_____

City _____ State ____ Zip_____

E-mail address _____

COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE/DOMESTIC PARTNER AND/OR CHILDREN:

Spouse/Domestic Partner:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex ____

Social Security Number _____

Occupation _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age_____

Social Security Number _____

COMPLETE THE FOLLOWING PLAN CHOICES:

Coverage Effective Date:

[□ Day after US Post Office Date Stamp

□ Later Effective Date: _____

● No more than [60] days in advance]

Coverage Length:

[□ **Single Payment:** *Specify number of days of coverage*

____ days *(minimum* [*30*] *days, maximum* [*365*] *days)* or

□ **Monthly Payment:**

□ Up to [6] Months

□ Up to [12] Months]

□ **[Secure] STM Plan**

Coinsurance:

[□ 80/20 of $5,000 □ 50/50 of $5,000 □ 80/20 of $10,000 □ 50/50 of $10,000 □ 100%]*

*100% not available with $250 or $1,000 Deductible]]

Deductible:

[□$250 □ $500 □ $1,000 □ $2,500 □ $5,000 □ $10,000 □ $25,000]

[□ **Daily Deductible STM Plan**

Coinsurance:

Not applicable

Deductible:

□ $250 □ $500 □ $750 □ $1,000]

[□ **Optional Supplemental Accident Benefit**

□ $500 □ $1,000]

[Optional Coverage - Hearing Aids

□ Accept □ Reject]

[Method of Payment

□ Check or Money Order

□ Credit Card

□ Monthly Automatic Bank Withdrawal]

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

Misstatements and omissions may be a material misrepresentation and a basis for rescission of coverage. In the event of rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) all claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be deducted from any premium refund due.

1. Will there be any other group or individual major medical health insurance in force on the policy effective date? ..... □ Yes □ No
2. Are you or any person applying for coverage now pregnant? ..... □ Yes □ No
3. Are you or any person applying for coverage currently eligible for Medicaid? ..... □ Yes □ No

[4. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? ..... □ Yes □ No]

[5.] Within the past [5] years have you or any person applying for coverage been aware of, received an abnormal test report for, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for:

■ heart disorder, heart attack, coronary artery disease, coronary bypass or stent ■ peripheral vascular disease or carotid artery disease ■ stroke or other neurological disorder ■ cancer or tumor	■ paraplegia, quadriplegia or multiple sclerosis ■ stem cell transplant ■ emphysema or COPD (chronic obstructive pulmonary disease) ■ insulin-dependent diabetes ■ liver disorder	■ kidney disorder other than stones ■ degenerative disc disease or herniated disc ■ rheumatoid or psoriatic arthritis ■ degenerative joint disease of the knees or hips ■ alcohol or drug abuse or dependency ■ hemophilia

..... □ Yes □ No

[6.] Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS ....□ Yes □ No

[[7.]Has any person proposed for coverage not been a legal resident of the United States for the last [12] consecutive months?..... □ Yes □ No]

([NOTE: IF "YES IS ANSWERED ON ANY QUESTION 1 THROUGH [7], COVERAGE CANNOT BE ISSUED].)

ACCEPTANCE AND ACKNOWLEDGEMENT:

A. I agree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
B. I hereby request coverage under the policy issued to the group policyholder. I agree to all terms of the group policy if the coverage applied for becomes effective.
C. I understand that the agent or broker who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied (1) was acting as an independent contractor and not as an agent of the Insurance Company; (2) was retained by me as my agent; and (3) has no right to alter the application, bind or approve coverage or alter any of the terms or conditions of the policy.
D. I certify that (1) I have read this application; (2) all of my (our) answers are within my (our) personal knowledge; and (3) all of my (our) answers are complete, true and correct.
E. I agree to immediately notify the insurer of any changes in any of the information contained in this application which may occur prior to the Effective Date of coverage.
F. I understand that health insurance benefits are excluded for pre-existing conditions and this coverage will not pay benefits for a disease or physical condition that I now have or have had within [5] years of my application for coverage.
G. I understand that cancellation of this coverage within the 10 Day Right to Return the Certificate provision as stated in the Certificate of Insurance will result in a refund of premiums only. [Any administrative fees or other fees that may apply will not be refunded].

Signature of Applicant or (Legal Guardian): _____ **Date:** _____

Signature of Spouse/Domestic Partner: _____ **Date:** _____

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[Plan Name]

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
SHORT TERM MEDICAL INSURANCE APPLICATION

COMPLETE THE FOLLOWING TO INSURE YOURSELF:

Applicant:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex _____

Social Security Number_____

Occupation _____

Telephone _____

Street Address _____

_____

City _____ State _____ Zip_____

Billing Address (if different) _____

_____

City _____ State ____ Zip_____

E-mail address _____

COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND/OR CHILDREN:

Spouse:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex ____

Social Security Number _____

Occupation _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age_____

Social Security Number _____

COMPLETE THE FOLLOWING PLAN CHOICES:

Coverage Effective Date:

[□ Day after US Post Office Date Stamp

□ Later Effective Date: _____

● No more than [60] days in advance]

Coverage Length:

[□ **Single Payment:** *Specify number of days of coverage*

____ days *(minimum [30] days, maximum [365] days)* or

□ **Monthly Payment:**

□ Up to [6] Months

□ Up to [12] Months]

□ **[Secure] STM Plan Coinsurance:**

[□ 80/20 of $5,000 □ 50/50 of $5,000 □ 80/20 of $10,000 □ 50/50 of $10,000 □ 100%]*

*100% not available with $250 or $1,000 Deductible]]

Deductible:

[□$250 □ $500 □ $1,000 □ $2,500 □ $5,000 □ $10,000 □ $25,000]

[□ **Daily Deductible STM Plan Coinsurance:**

Not applicable

Deductible:

□ $250 □ $500 □ $750 □ $1,000]

[□ **Optional Supplemental Accident Benefit**

□ $500 □ $1,000]

[Optional Coverage - Hearing Aids

□ Accept □ Reject]

[Method of Payment

□ Check or Money Order

□ Credit Card

□ Monthly Automatic Bank Withdrawal]

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

Misstatements and omissions may be a material misrepresentation and a basis for rescission of coverage. In the event of rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) all claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be deducted from any premium refund due.

1. Will there be any other group or individual major medical health insurance in force on the policy effective date? ..... □ Yes □ No
2. Is the proposed insured, spouse, or any dependent child now pregnant? ..... □ Yes □ No
3. Have you or any person applying for coverage been declined for health insurance for a condition that is still present? ..... □ Yes □ No
4. Are you or any person applying for coverage currently eligible for Medicaid? ..... □ Yes □ No

[5. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? ..... □ Yes □ No]

[6.] Within the past [5] years have you or any person applying for coverage been aware of, received an abnormal test report for, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for:

■ heart disorder, heart attack, coronary artery disease, coronary bypass or stent ■ peripheral vascular disease or carotid artery disease ■ stroke or other neurological disorder ■ cancer or tumor	■ paraplegia, quadriplegia or multiple sclerosis ■ stem cell transplant ■ emphysema or COPD (chronic obstructive pulmonary disease) ■ diabetes ■ liver disorder	■ kidney disorder other than stones ■ degenerative disc disease or herniated disc ■ rheumatoid or psoriatic arthritis ■ degenerative joint disease of the knees or hips ■ alcohol or drug abuse or dependency ■ hemophilia

..... □ Yes □ No

[7.] Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS ....□ Yes □ No

[[8.]Has any person proposed for coverage not been a legal resident of the United States for the last [12] consecutive months?..... □ Yes □ No]

([**NOTE: IF "YES IS ANSWERED ON ANY QUESTION 1 THROUGH [8], COVERAGE CANNOT BE ISSUED].**)

ACCEPTANCE AND ACKNOWLEDGEMENT:

A. I agree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
B. I hereby request coverage under the policy issued to the group policyholder. I agree to all terms of the group policy if the coverage applied for becomes effective.
C. I understand that the agent or broker who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied (1) was acting as an independent contractor and not as an agent of the Insurance Company; (2) was retained by me as my agent; and (3) has no right to alter the application, bind or approve coverage or alter any of the terms or conditions of the policy.
D. I certify that (1) I have read this application; (2) all of my (our) answers are within my (our) personal knowledge; and (3) all of my (our) answers are complete, true and correct.
E. I agree to immediately notify the insurer of any changes in any of the information contained in this application which may occur prior to the Effective Date of coverage.
F. I understand that health insurance benefits are excluded for pre-existing conditions and this coverage will not pay benefits for a disease or physical condition that I now have or have had within [5] years of my application for coverage.
G. I understand that cancellation of this coverage within the 10 Day Right to Return the Certificate provision as stated in the Certificate of Insurance will result in a refund of premiums only. [Any administrative fees or other fees that may apply will not be refunded].

Signature of Applicant or (Legal Guardian): _____ **Date:** _____

Signature of Spouse: _____ **Date:** _____

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(SSL Secure STM APP 1-09)

[Plan Name]

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
SHORT TERM MEDICAL INSURANCE APPLICATION

COMPLETE THE FOLLOWING TO INSURE YOURSELF:

Applicant:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex _____

Social Security Number_____

Occupation _____

Telephone _____

Street Address _____

_____

City _____ State _____ Zip_____

Billing Address (if different) _____

_____

City _____ State ____ Zip_____

E-mail address _____

COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE/DOMESTIC PARTNER AND/OR CHILDREN:

Spouse/Domestic Partner:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex ____

Social Security Number _____

Occupation _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age_____

Social Security Number _____

COMPLETE THE FOLLOWING PLAN CHOICES:

Coverage Effective Date:

[□ Day after US Post Office Date Stamp

□ Later Effective Date: _____

● No more than [60] days in advance]

Coverage Length:

[□ **Single Payment:** *Specify number of days of coverage*

____ days *(minimum* [*30*] *days, maximum* [*365*] *days)* or

□ **Monthly Payment:**

□ Up to [6] Months

□ Up to [12] Months]

□ **[Secure] STM Plan**

Coinsurance:

[□ 80/20 of $5,000 □ 50/50 of $5,000 □ 80/20 of $10,000 □ 50/50 of $10,000 □ 100%]*

*100% not available with $250 or $1,000 Deductible]]

Deductible:

[□$250 □ $500 □ $1,000 □ $2,500 □ $5,000 □ $10,000 □ $25,000]

[□ **Daily Deductible STM Plan**

Coinsurance:

Not applicable

Deductible:

□ $250 □ $500 □ $750 □ $1,000]

[□ **Optional Supplemental Accident Benefit**

□ $500 □ $1,000]

[Optional Coverage - Hearing Aids

□ Accept □ Reject]

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□ Credit Card

□ Monthly Automatic Bank Withdrawal]

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

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1. Will there be any other group or individual major medical health insurance in force on the policy effective date? ..... □ Yes □ No
2. Are you or any person applying for coverage now pregnant? ..... □ Yes □ No
3. Are you or any person applying for coverage currently eligible for Medicaid? ..... □ Yes □ No

[4. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? ..... □ Yes □ No]

[5.] Within the past [5] years have you or any person applying for coverage been aware of, received an abnormal test report for, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for:

■ heart disorder, heart attack, coronary artery disease, coronary bypass or stent ■ peripheral vascular disease or carotid artery disease ■ stroke or other neurological disorder ■ cancer or tumor	■ paraplegia, quadriplegia or multiple sclerosis ■ stem cell transplant ■ emphysema or COPD (chronic obstructive pulmonary disease) ■ insulin-dependent diabetes ■ liver disorder	■ kidney disorder other than stones ■ degenerative disc disease or herniated disc ■ rheumatoid or psoriatic arthritis ■ degenerative joint disease of the knees or hips ■ alcohol or drug abuse or dependency ■ hemophilia

..... □ Yes □ No

[6.] Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS ....□ Yes □ No

[[7.]Has any person proposed for coverage not been a legal resident of the United States for the last [12] consecutive months?..... □ Yes □ No]

([NOTE: IF "YES IS ANSWERED ON ANY QUESTION 1 THROUGH [7], COVERAGE CANNOT BE ISSUED].)

ACCEPTANCE AND ACKNOWLEDGEMENT:

A. I agree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
B. I hereby request coverage under the policy issued to the group policyholder. I agree to all terms of the group policy if the coverage applied for becomes effective.
C. I understand that the agent or broker who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied (1) was acting as an independent contractor and not as an agent of the Insurance Company; (2) was retained by me as my agent; and (3) has no right to alter the application, bind or approve coverage or alter any of the terms or conditions of the policy.
D. I certify that (1) I have read this application; (2) all of my (our) answers are within my (our) personal knowledge; and (3) all of my (our) answers are complete, true and correct.
E. I agree to immediately notify the insurer of any changes in any of the information contained in this application which may occur prior to the Effective Date of coverage.
F. I understand that health insurance benefits are excluded for pre-existing conditions and this coverage will not pay benefits for a disease or physical condition that I now have or have had within [5] years of my application for coverage.
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Signature of Spouse/Domestic Partner: _____ **Date:** _____

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